



Family Name: _____

Congregation Tikvat Jacob 2011-12

Religious School Application

Please complete the following information for **all** children who will attend Religious School:

Class	Fee	Name of Child(ren) Attending
Kindergarten, 1st, 2nd Grade – Sundays 9am-11:15am	\$820	
3rd Grade – Tuesday, 4pm-6:30pm & Sunday, 9am-11:15am	\$1130	
Optional Retreat- Nov. 4 - 6, 2011	\$170	
3rd Grade- Wednesday, 4pm-6:30pm, Sunday, 10:45am-1pm	\$1130	
Optional Retreat- Nov. 4 - 6, 2011	\$170	
4th Grade – Tuesday, 4pm-6:30pm & Sunday, 9am-11:15am	\$1300	
4th Grade – Wednesday, 4pm-6:30pm & Sunday, 10:45am-1pm	\$1300	
5th Grade – Tuesday, 4pm-6:30pm & Sunday, 9am-11:15am	\$1300	
5th Grade – Wednesday, 4pm-6:30pm & Sunday, 10:45am-1pm	\$1300	
6th Grade – Tuesday, 4pm-6:30pm & Sunday, 9am-11:15am	\$1300	
6th Grade – Wednesday, 4pm-6:30pm & Sunday, 10:45am-1pm	\$1300	
7th Grade – Tuesday, 4pm-6:30pm & Sunday, 9am-11:15am	\$1300	
7th Grade – Wednesday, 4pm-6:30pm & Sunday, 10:45am-1pm	\$1300	
Noar (8th-12th Grade) Wednesday, 6:30pm-9pm	\$625*	
Optional Retreat- May 4-6, 2012	\$170	
Bar/Bat Mitzvah Fee**	\$1125	

* Non-refundable after July 31st

** Contact the B'nai Mitzvah Director for more information

Retreat Dates: 3rd-6th grades, November 4 – 6, 2011; 7th – 12th grades, May 4-6, 2012

Does the child (ren) reside with both parents? (Circle one)	Yes	No
If not:		
With whom? _____		
Should both parents receive school material? (Circle one)	Yes	No

Family Name: _____



Congregation Tikvat Jacob 2011-12

Volunteer at the Religious School

You make a difference: (1) in the success of the programs and activities of our Religious School, (2) in your child's Jewish education and (3) in your family life.

Let us know how you would like to volunteer by checking all the ways you can help below. **Please indicate WHO in your family can help with each task.**

Volunteer Name:	
	Room Parent
	Phone class families
	Purim Carnival
	Help with food preparation
	School Board
	Substitute Teacher
	Tot Shabbat
	Drive Carpool for Field Trips
	Fundraisers
	Hebrew Tutoring
	Other, specify: _____

Family Name: _____



Congregation Tikvat Jacob 2011-12

Congregation Tikvat Jacob

3rd-12th Grade Religious School Retreat Release Form

November 4 – 6, 2011 (3rd-6th grade) or May 4- 6, 2012 (7th-12th grade)

Name of Participant: _____ Age: _____ Grade: _____

Name(s) of Parent(s)/Guardian(s): _____

Home Phone #: _____ Cell/Pager # _____

Emergency Contact and Phone: _____

Medical Insurance Company: _____

Policy Number: _____ Allergies: _____

I hereby give my permission for my child to participate in CTJ's Conclave Religious School Retreat at Camp Shalom in Malibu. Activities at Camp Shalom will include, among other things, rope course activities, crafts, archery and hiking. I understand that all Camp Shalom activities will be supervised by hired Camp Shalom staff.

I also release Congregation Tikvat Jacob and its representatives from all liability arising out of my child's participation in such activity.

In addition, I, the undersigned parent/guardian of the above child, do further certify that my child is physically able to participate in such activity and hereby authorize CTJ and its authorized representatives as agents for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services which is/are to be rendered under the general or specific supervision of any licensed physician (under the provisions of the California Medicine Practice Act) or the staff of a licensed hospital, whether such a diagnosis, examination or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any such activity being required, and is given to provide authority and power on the part of our above named agents to give specific consent to any and all such examinations, diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

The Authorization is given pursuant to the provisions of § 6910 of the Family Code of California.

I have read and fully agree to the medical/liability form above:

Parent/Guardian Signature: _____ Date: _____

Congregation Tikvat Jacob 2011-12

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Congregation Tikvat Jacob

SHALOM INSTITUTE: CAMP AND CONFERENCE CENTER

34342 Mulholland Hwy. , Malibu , CA 90265

SHALOM RETREAT CENTER

INFORMATION AND AUTHORIZATION FORM



Please Select :

- 3rd-6th – November 4 - 6
- 7th-12th May 4 – 6

STUDENT INFORMATION

Student's Name:	() Male () Female	Birth date (MM/DD/YY)	Age as of 09/01/11:	Current Grade:
Street Address:	City:	State:	Zip:	
Email Address: _____				

PARENT INFORMATION

Parent #1 Name:	Parent #1 Email:	Parent #1 Pager:
Parent #1 Home Phone: ()	Parent #1 Work Phone: ()	Parent #1 Cell Phone: ()
Parent #2 Name:	Parent #2 Email:	Parent #2 Pager:
Parent #2 Home Phone: ()	Parent #2 Work Phone: ()	Parent #2 Cell Phone: ()
Student lives with: () Both Parents () Mother () Father () Other:		

IN CASE OF EMERGENCY, IF PARENTS ARE UNAVAILABLE, PLEASE CONTACT:

Name _____	Home: _____	Work: _____
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BUNKMATE REQUESTS (We will try our best to honor all requests.)

1. _____	2. _____	3. _____
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MEDICAL INFORMATION

PLEASE INDICATE ANY ALLERGIES, SPECIFIC MEDICAL CONCERNS, AND/OR DIETARY RESTRICTIONS:

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

1. MEDICATION: _____	DOSAGE: _____	FREQUENCY: _____
2. MEDICATION: _____	DOSAGE: _____	FREQUENCY: _____
3. MEDICATION: _____	DOSAGE: _____	FREQUENCY: _____

MEDICAL INSURANCE COMPANY _____

INSURANCE POLICY NUMBER _____

PHYSICIAN TO BE CONTACTED IN CASE OF EMERGENCY _____

PHYSICIAN'S PHONE NUMBER _____

ADDITIONAL INFORMATION

Is there any other information you think might be useful to us? (Special needs, behavioral issues, etc.)

USE ADDITIONAL SPACE ON REVERSE SIDE IF NECESSARY

PLEASE FILL OUT REVERSE SIDE

ADDITIONAL INFORMATION (Continued from other side):

SHALOM RETREAT CENTER TERMS OF REGISTRATION & PARENT AUTHORIZATION *

1. Shalom Institute may use any photograph, slide, video or likeness of my child for camp publicity or other publications associated with the camp..
2. Shalom Institute accepts no responsibility for loss or damage to any student's property during the retreat.
3. At the discretion of the camp director, my child may be sent home because of behavioral problems, the bringing of alcohol, drugs, and/or cigarettes to camp.
4. I agree to have our name, address, e-mail, and phone number listed on a retreat roster to be distributed to all families.
5. I give my child permission to participate in all the activities during the retreat, including ropes course and hikes.
6. Shalom Institute has my permission to provide routine non-surgical medical care. In the event of a medical emergency and I cannot be reached, I hereby give permission to the Physician selected by the Camp Director or his agent, to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child as named herein.
7. I understand that I am responsible for costs incurred on behalf of my child relating to accident or illness when treated outside of camp. I authorize payment of medical benefits to physician or supplier for services rendered while my child is at Shalom Institute.
8. (I) / (We), the undersigned, parent(s) of _____, a minor, do hereby authorize the Director of the Shalom Institute, or his/her authorized representative, as agent(s) for the undersigned, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medicine Practice Act on the medical staff of a licensed hospital, whether such examination, diagnosis or treatment is rendered at the office of said physician or at such a hospital.
9. It is understood that this authorization is given in advance of any specific examination, diagnosis, treatment or hospital care being required, and is given to provide authority and power on the part of our above-named agent(s) to give specific consent to any and all such examinations, diagnoses, treatments or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is give pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until the Shalom Institute receives written notification from you canceling this consent form.
10. I _____ (Parent's Name) will indemnify, save harmless and defend: Jewish Federation Council of Greater Los Angeles, its officers, directors, agents, and employees, the Shalom Institute, its officers, directors, agents, and employees from all liability from loss, damage, or injury to persons or property in any manner arising out of or incident to the performance of this agreement including without limitation all consequential damages and/or attorney's fees.

I certify that all of the information on this application is true and accurate. I have read and agreed to the above Shalom Institute Terms of Registration and Parent Authorization.

Parent/Guardian Signature

_____/_____/_____
Date of Application

Please add us to the Shalom Institute mailing list. We would love more information on Shalom Institute year-round programs.